| • | | | O A TOTAL | OSHA File | , |
|--|--|---|--|-------------------------|--------------------------------|
| GEORGIA STATE | BOARD OF WOR | KERS' COMPEN | SATION | No. | |
| EMPLOYER'S FIRST R | FPORT OF INJURY | OR OCCUPATIONAL | L DISEASE | Insurer Name and Ser | vicing Agent Address |
| | Department | Employer Phone: No. | 7-7066 | KAK | INSULEN |
| iployer | hot redu | Regular Occupation | 1 2000 25 20 21 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 | - Address | |
| dress | Specific Products | 11)Rest | 120 | | State/Zip |
| 0. 105 105 3. 0 Sand | Neoure of Business (1) | fig.; Frade, Transp., Etc.) | Sec. 38.36-38 | Fort Way | IN 46801 |
| ry | | ANCAHA.A) //W | Injury | Employee Social Sec | urity Number |
| nployee Name (Last): First): k(Middle) | is in the second of the second | 10.100 | | 252 33 2 | |
| SOLL LUBIKER | Transparation (1997) | 1 OC 7 12 199 | | Male Pemale | DO NOT WRITE IN THIS COLUMN |
| ddress | | ູ່ໄຊງ | | <u> </u> | |
| 5/1 mossived lank | V - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - | Number of | Dependents Includi | ng Spouse | Insurer No. |
| ity 200 | | 4758 2 | | 1: County | SIC |
| lace of Accident of Exposure (Address: | r Location) | | | Commy | Age |
| | | | - · · · · · · · · · · · · · · · · · · · | <u>¥</u> | Sex |
| On: Employer's Premises | of Injury Time Workda | y Begin First Date | Employer Aware | | Occupation |
| A Comment | am() pm | 1 11 | 755/26 | in almania | - |
| Yes No | | First Date Employee Failed to Work a Full Day | Did Employee Pay for Date of | Receive Pull Injury? | . Course of Injury |
| ength of Time in Your Did E imploy | Day? | | V Ves D No | | County of Injury |
| (ears () Months () Pe | | Scheduled Wave Rat | ear time of injury | | Employer Aware |
| Idurs Worked Number of L | Off Days | Coste | Het 2 Ho | ur () Day () | - Employer |
| er Day (| | | | ek () Mo. () | Nature |
| er Week() Week(| a myenene li bo | ard, lodging, or other | If Return to W | | [Tattero |
| Per Week COMPLETE WAGE STATEMENT ON If employee is paid hourly, on commissi basis, enter average weekly amount | on or piecework advar | ringes were furnished; enter ige weekly amount. | Returned at W | hat Wage | Body Part |
| basis, enter average weekly amount | 7 | • | | per week | |
| 11/4 diCAU OL | the filtery or Occupational Disease h | Denil. Include the surper of injury | sind indicate to part of the Control | dy, affected, | Cause |
| 1726796 Witestlew or | i to and with | ~ 15 this upg | cian the | mad I | |
| T hart my hope I | s the early fo | _ 1 | twould be | CKAU I | |
| distant do any thing a | bail it becau | 199 If Famil: Give Di | ie of Death | | м.о. |
| relation it in Germ | me an OCF II | Initial Treatment | Hospital (Na | me & Address) | Controvert |
| Treating Physician Name and Address | o Chipie | D No Treatment | | · | Conduser |
| PEACHILEE GOTH | o. Chipping! | n Minor: By Employer Minor: Clinic/Hospita D Emergency Care | 4 | | D. First |
| HARISCIELD CENT | a Branch | Hospitalized > 24 hrs | | • | D. rux |
| AHI CAP YOU | 1-204-4131 | | | | Date of/Report/ |
| Report Prepared By (Print or Type) | Po | 7 20 | Telephone Number | <i>[[-]]</i> | 11/24/96 |
| ALAMA UA MAN | 76, 1/1 | THE PROPERT TO INSURE | RIMMEDIATELY | MAY RESULT IN P | NALTY |
| EMPLOYER'S | FAILURE TO SUBMIT THE | USE BY INSURER/SELF | INSURER | | |
| В. | Weakly benefit S | | ability | Date of first paymen | H |
| Average weekly wage \$ | Penalty paid: S | | | | |
| Compensation paid: \$ | . | _, 19 FOR: | | i | for weeks |
| BENEFITS ARE PAYABLE FROM D Total/temporary total disability | Temporary partial disability | D Permanent partial disabi | lity of | Part of Body | SIONS REQUIRE THE |
| O Total/temporary total disability | WHEN THE EMPL | OYEE ACTUALLY RETUR | AND THE EMPLO | YEE. | |
| BENEFITS ARE PAYABLE FROM O Total/temporary total disability UNTIL FILING OF FORM WC2 WITH TH | E STATE BOXED OF WO | | | (Phone) | DEFENDAN |
| | | 400-1-1 | | 4 | EXHIBIT |
| NOT | ICE TO CONTROVERT | PAYMENT OF COMPENS | ATTUN COVERTOR B | | 6 |
| C. Benefits will not be paid because: | | | | | |
| | | (Date) | | (Phone) | |
| By (Insurer-Self-Insurer: T | ype or Print and Sign) | , | | WCW 01971 | |
| | | | | CONFIDENTI | Δ1 |

DEC-02-96 MON 02:15 PM PEACHTREE ORTHOPAEDIC

FAX NO. 4043552136

P. 02

Name: WALKER, Bobby

Chart Number: 15599

Date of Birth: 09/04/64

Age: 32

Date: 11/26/96

PROGRESS NOTES

NOVEMBER 26, 1996, SWS/wzlm:

Bobby is a 32-year-old wrestler on the WCW Network, HISTORY OF PRESENT ILLNESS: who was jumping off of a top rope on 10-1-96 and landed wrong, twisting his left knee. He felt a pop. He had swelling and iced it immediately. He has been wearing a brace for wrestling. He is able to wrestle and at this time states that he is 90% better. He still has some pain with full extension and pain in the popliteal area down the left leg with flexion. He occasionally feels unstable and occasionally has painful popping in his left knee.

PAST MEDICAL HISTORY:

None.

PAST SURGICAL HISTORY:

Left eye surgery.

MEDICATIONS:

None.

ALLERGIES:

None.

The patient has a left knee with no effusion. There is PHYSICAL EXAMINATION: a medial joint line tenderness at the posterior corner, however, otherwise there is no tenderness. He is non-tender laterally. There is no ligamentous instability. The calf is non-tender. Neurovascular examination of the left, lower extremity is normal.

RADIOGRAPHS:

AP, lateral and sunrise radiographs of the left knee,

show no apparent abnormality.

Twisting injury of the left knee with medial joint line IMPRESSION AND PLAN: tenderness at the posterior corner. He may well have a small meniscal tear, however, since he states he is 90% better and is able to wrestle, then I would favor continued conservative management. We will see him back in three to four weeks, at which time we will have another discussion. If he continues to have or starts to have severe problems, would favor an MRI of the knee and possible interventional management.

(cc: Crawford & Company-

-Stephen W. Smith, M.D.)

| PLOYER " | Un (12/65) | PRINT C | | soc. sec. no.; 252 | -33-26 | 57. | Date . 6/19/ |
|--------------------|-------------------|---|---|-------------------------------|----------------|-------------|-----------------------------|
| DRESS | • | | | DATE OF BIRTH | 2/04/ | 1 | lity Date 6/19/ |
| īΥ | | STATE | ZIP | INSURER FILE | 10. | • | |
| ſ | EMPLOYEE BUBBY | UALKER 7: | INSURER | AWFORD & C | OMPAN | • | ٦ |
| | ADDRESS M | DSSWOOD LANE | ADDRESS | b BUX 5206 | 7 | | |
| | CIRYEX . G | A 30273 STATE ZIP | CITY AT | LANTA, SAT | 90355 | . ZIP | |
| · | L | | · . L= | • | · . | | |
| e above emp | ovee address wi | Il be used by the Board. Employee must report any | changes. | | | | l no vo |
| DATE OF SERVICE | CPT/CRV CODE | MEDICAL AND SURGICAL SERVICES | (ITEMIZE AND DES | CRIBE) | io. of RATE | AMOUNT | DO NOT |
| 6/26/9 | 7 99213 | OFFICE VISIT | | | | 56.00 | |
| | | | | | | | |
| · • • | | | | | | | |
| | • | | | | | | • |
|) : | | | | | | | |
| | | | | • 1 | | | |
| • • | | | • | | | | |
| • | | | | | | | |
| | | | | | | ; | 1 |
| • | TOTAL | | | • | | 56.00 | > |
| | | PLEASE COMPLET | E EÁCH ITEM BE | LOW: | | | nes |
| 3. DATE DI | SCHARGED AS | CURED . UNDETERMINED | NA. | | | WI) HOO! ON | |
| 5. DATE PA | TIENT REFUS | ED TREATMENT | 1 | TO RETURN TO | (7) | IGHT (| NORMA |
| 7. DATE O | F MAXIMUM R | | INFC | AL REHABILITAT ESSARY ()! | PROBABLE | [| UNLIKE |
| LAVEC | laansika marmamis | E ANY PERMANENT DISABILITY RESULTING | FROM THIS INJURY | ? (If emputation is | involved, st | WC | W 019 [*] FIDEN |
| | | NY LOSS OF VISION OR HEARING, PLEASE GIV ted visual acuity — Right eye Left eye (HEA | VE AMOUNT OF DIS ARING) Left ear 500 Right ear 50 | 1K | | 2K | |

FROM : NORTH COBB ORTHO

PHONE NO. : 7704210613

Jun. 26 2091 02:23PM P1

OrthoCompWorks OrthoCompWorks Information...Direct Line 770-422-3290 Service of North Cobb Orthopsedlo & Sports Medicine Associates, RA.

211 Chicopee Drive Marietta, GA 30060

| Patie Name Chart Date o Date o Adjus Phone | ent Information Copy Walker 39380 of Injury:(a 19197 of Visit: 12 26 97 ter:Pat Aaww Number: | Visit Status Initial Visit IME 2nd Opinion Return Visit Annual Visit Final Evaluation |
|--|--|--|
| PH | SICIAN USE ONLY: | |
| 1. | Diagnosis Unchanged ACL TROW (A) KLUE 5. | Care Plan Next Appointment: (in weeks) Mon. Tues. Wed. Thur. Fri. Mon. Tues. Wed. Thur. Fri. 1 2 3 4 5 6 |
| 2. | Condition Improving Worsening Unchanged | Weeks Months Annual PRN Further Treatment Recommended: |
| 3. | Prescribed Drugs A B C Work Status No wresturg cuttle | Other |
| 4. | No Work | Restrictions: 4. Patient wants to white Obout surgry-possibly plus I'm opinion |
| | JUN 26 '97 12:59PM PACES FERRY IMAGING | |

FROM : NORTH COBB ORTHO

PHONE NO. : 7704210613

Jun. 25 2091 03:29PM P1

TO: Bruda 5 mish 404-351-428, OrthoCompWorks

Appointments and Information...Direct Line 770-422-3290

211 Chicopee Drive Marietta, GA 30060

| Servi A Sp | ice of North Cobb Orthopsedic ports Medicine Associates, P.A. | manetta, GA 40000 |
|--|--|---|
| Patie Name Chart Date of Date of Adjust | ent Information 39580 of Injury: 6/1997 of Visit: 6/25/97 ster: Rost Haawin (Crawford 400) e Number: 404-8/199-2147 | Visit Status Initial Visit IME 2nd Opinion Return Visit Annual Visit Final Evaluation |
| PH' | YSICIAN USE ONLY: | |
| 1. | Diagnosis Unchanged Possible ACL Tear | Next Appointment: (in weeks) Mon. Tues. Wed. Thur. Fri. Mon. Tues. Wed. Thur. Fri. 1 2 3 4 5 6 |
| 2. | Condition Improving Worsening Unchanged | Weeks Months Annual PRN MRI 6 25 978 40m Further Treatment Recommended: |
| 3. | Prescribed Drugs A B C | Other Surgery Referral |
| 4. | Work Status No running, proting, Or practicing. No Work Full Time Full Duty Part Time Light Duty MMI Date | Imaging MCI (E) KALL 6. Restrictions: |
|) | PPI % Whole Man Indemnity ClosedYesNo | Dr.'s Initials: W86 |

WCW 019742 CONFIDENTIAL



Pacus Imaging - Buckhead 3193 Howell Mill Road - Suite 110 Atlanta, Georgia 30327 (404) 352-0444 Fax (404) 352-2529

Paces Imaging - Midtown 600 West Peachtree Street - Suite 140 Autanus, Coorgia 30308 (404) 875-2640 Fax (404) 874-6752

WILLIAM CIBBONS MD 211 CHICOPEE DRIVE MARIETTA GA 20060

Patient:

WALKER, BOBBY Name:

9/04/64 DOB: M

Sex:

SSN: 252-33-2657

Date of Exam: 6/25/97

MRI OF THE RIGHT KNEE: T1 weighted coronal and parasagittal image series were obtained as were dual acquisition sagittel oblique images and finally a T2 weighted 3D volume acquisition was made for use with the ViStar.

The collateral ligaments appear normal as does the posterior cruciate ligament but the anterior cruciate ligament is completely missing. The quadriceps and patellar tendons appear intact. There is modest bony degenerative change with a little osteophytic lipping of the medial tibial plateau and medial temoral condyle. Also there are what appear to be pure chondral fractures involving the posterior aspects of both the medial and lateral femoral condyles (B12, B14; B36, B38). The retropatellar articular cartilage looks normal. I think there has been a previous partial medial meniscoctomy. The remnant looks a little irregular (814) but I do not see a residual or recurrent tear. I think the lateral meniscus is intact. There is a moderate effusion but I do not see a Baker's cyst.

THERE IS COMPLETE ABSENCE OF THE ANTERIOR CRUCIATE CONCLUSION: LIGAMENT SUGGESTING CHRONIC DEFICIENCY. ALSO I THINK THERE HAS EEEN A PREVIOUS PARTIAL MEDIAL MENISCECTOMY. THE REMNANT LOOKS A LITTLE IRREGULAR (B14). ALSO THERE ARE WHAT APPEAR TO BE PURE CHONDRAL FRACTURES OF THE ARTICULAR CARTILAGE OVERLYING THE MEDIAL (812) AND LATERAL (836) FEMORAL CONDILES. FINALLY THERE IS A FAIRLY SIZEABLE JOINT EFFUSION.

S. Boyd Eaton, M.D.

da D: 6-26-97 T: 6-25-97

BITTIDING ON THE TRADITIONS OF EXCELLENCE...

Jeny Oumereik, M.D. . S. Boyd Earon, M.D. . Barham C. Erwin, M.D. Brigid Gurety, M.D. . William C. Lang, Ja., M.D. . Eric C. Lund, M.D.

NORTH COBB ORTHOPAEDIC & SPORTS MEDICINE ASSOCIATES, P.A.

JOHN D. KNOX, JR., M.D.
ALFRED O. COLQUITT, III, M.D.
WILLIAM S. GIBBONS, M.D.
BRADLEY E. HENDERSON, M.D.
211 CHICOPEE DRIVE
MARIETTA, GEORGIA 20040
(170) 422-2290
FAX (170) 421-6113
ORTHOPEDIC SURGERY

8/25/97

MEDICAL REPORT:

RE: Bobby Walker

HISTORY:

This 32-year-old WCW is seen today for sprain in the right knee. Jumping off the rope, he twisted his knee on 6/19/9Z. He telt no discernible pop. He developed moderate swelling over the next 12-24 hours. Since that time he has had pain medially and laterally in the knee along with catching and low-grade giving way episodes. He has had previous arthroscopic surgery on this knee for what sounds like chronic subluxation of the patella.

Reveals healthy, heavily muscled black male. He has excellent thigh tone in the right leg. There is 1+ effusion. He is tender in the anterior medial and mid lateral joint line. He has no collateral ligament laxity. He has a 2+ Lachman's with soft endpoint. Pivot shift is mildly positive. Will allow about 90 degrees of flexion and McMurray's cannot be adequately tested through the range possible. Distal NV exam is normal.

X-RAYS:

Negative.

IMPRESSION:

Sprain, right knee, with probable tear of the anterior cruciate ligament and questionable meniscal disruption.

DISPOSITION:

Advised MRI to assess the damage. Rest the knee in the meantime. Carry out gentle range of motion and isometric quad simngificating. I will see him back following the MRI for further discussion and disposition.

WILLIAM S. GIBBONS, M.D.

WSG:sbm

WCW 019744 CONFIDENTIAL

Chartant Dien 6/25/97

NORTH COBB ORTHOPAEDIC & SPORTS MEDICINE ASSOCIATES, P.A. JOHN D. KNOX, JR., M.D.

ALFRED O. COLQUITT, III, M.D. WILLIAM S. GIBBONS, M.D. BRADLEY E. HENDERSON, M.D. 211 CHICOPES DRIVE MARIETTA, OBORGIA 30080

CLINICAL DATA GENERAL

AGE

SEX

SMWD

week

PHONE

DATE

ADDRESS

SPONSOR

ACCRESS REF BY

ACKN

OCCUPATION

LANKI RESULOS:

6-26-97 PROGRESS NOTE: Bobby received MRI yesterday, which showed ACL deficiency. There was burning of the medial meniscus which was felt to be likely consistent with a previous meniscectomy. Taking these findings into account, one would wonder if his previous knee surgery was not a partial medial meniscectomy, at which time, ACL damage was noted in that he is now gone on to developed increased lastly and symptomatic problems with the knee in that regard. I would certain, in either regard, recommend arthroscopic ACL reconstruction for the reasons stated in his original note. The pros and cons of this are discussed, along with the down time involved. I have suggested he work for the next week to ten days on getting range of motion and quad strengthening going in his knee. This would be appropriate before surgery is undertaken in any regard. In the meantime, he may well want to get other opinions on this before deciding on a definite course of action. I will tentatively plan to see him back in 10 days for re-evaluation. WCW will be aware of the MRI findings and recommendations. WSG:kw

> WCW 019745 CONFIDENTIAL

| ELERAL I | N (00 | 10/17/ | DOLONEN | SATION | OSHA Pile | |
|--|------------------------------------|--|--|---------------------------------------|--|--|
| GEORGIA ST | ATE BOARI | OF WORKE | K2, COMPEN | OWING. | Investor File (W | |
| GEORGIA STA | RST REPORT. | OF INJURY OR | OCCUPATIONA | L DISEASE | Insurer/Solf Insurer N | lame . Note that the lamb |
| | | insolution in a c | Choch-loos | 7-7030 | | |
| One CNN C | 1/ | ific Products | Regular, Occupation | 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | Servicing Agent Nam | e & Address |
| SS of the sind | | Modesto | Just Cost (| Vesta. | ACIN: Market Miles | State/Zip: |
| Section Section | State/Zip Nati | are of Business (Mg., | Trade, Transp. Etc.) | Z | • | |
| 6312 C. 111 E. H. 111 C. 1111 | k 2/ | Dollas CMA | SAA A MOI | Injury / O | Employee Social Sec | curity Number |
| oyee Name (Last) (First) | Middle) & *** | SNAME OF THE SAME | 2/2! | 7198_ | 1000 | 3-2607 |
| UAKer. Bo | ושוכו | of Birth | | ** | Male Female | DO NOT WRITE IN THIS COLUMN |
| " A21 C1 | Owa | 14/64 | 3 | 2 | | V 1, 110, 110 110, 110, 110, 110, 110, 1 |
| JENLAY/E | BAV / | ployee's Home Ph. | Number o | Dependents Includ | ing Spouse | Tibolet 110. |
| LEVILLE | 3,214,10 | 40-716-68 | 30 | <u> </u> | County | SIC |
| of Accident of Exposure | | | Contraction of Contra | | FILL | Age |
| ATORY | in les | lei. | | | 110700 | ;; Sex |
| Employer's Premises | Time of Linjury | Time Workday Be | First Date | Employer Aware | Latin | Occupation |
| Employer's Premises | 1201M | am (7) pm () | 1921 | 198 Hapin | and the second s | |
| es D No | Did Employee W | ork the First | Date Employee ed to Work a Full Day | Did Employee Pay for Date o | Receive Full (lajury? | County of injury |
| gth of Time in Your | Next Day? .5 Vive | "carlos especial ye | | n Ves D No | | |
| Months () | D Yes PNO | List Normally Sch | eduled Wage Ra | A.B., 48.B.R.Y.A.4.99- 8.274.6 280 | or Disease | Employer Aware |
| | ked Pfr | Off Days | (ens | HOUT HO | our () Day () | 1 |
| | | Valu | | 196.2 | eek () Mo. () | Nature |
| Week Wee | k (V ENT ON REVERSI | If board, d | odging or other were furnished enter sekly amount | Give Date | 382 Section 24. | |
| MPLETE WAGESTATEM employee is paid bourty on ear any streets weekly an | commission or plece | average w | ekly amount | Returned N.V | 0403-38038: 385-012 transcrater | Body Part |
| X/ | 1) Lesto - | Lesontes + | sin afras | Elikeke) | per week | - - |
| Did the Accident to Exposure Occu | 7: Describe the layery of | Completion Disease in Detail | terms to dark it was | r and indicate the first of t | | Cause |
| MAN | Ton | 1 Cw Pone | INIANT. | Lowy Ho | WASHINT KNE | 5_ |
| wrig /1/HHO | 10.11 | 3/27- | Right K | nde) | | M.O. |
| ungen sche | ancer for | <u> </u> | it Famil Give D | ate of Death | | |
| <i>y</i> / | Address) | l in | ital/Treatment | Hospital (Ni | line & Address). | Controvert |
| rearing Physician (Name and | 2021 | 2 2 2 | No Treatment Minor: By Employer | | | - |
| VI chear | 12/16-1 | | Minor: By Employer Minor: Clinic/Hospit Emergency Care | | | D. First |
| 3280 Hon | rell Mil | | Hospitalized > 24 m | | | D. Past |
| Att. CA. | | · • | ICO Yes O No | | | U Date of Report |
| 7 / C. C/ | Type) | 55000 A TO THE PERSON OF THE P | | | 02-1070 | 11 2004-71 |
| Report Arehated Systems by | n42: | TIPAI | res Alla | R IMMEDIATELY | MAY RESULT IN P | ENALTY / |
| EMPLO | YER'S FAILURE | TO SUBMIT THIS R | BY INSURERISELI | INSURER | | |
| В. | | | Date of di | | Date of first payme | :nt: |
| Average weekly wage: \$ | | dy benefit: \$ Ity paid: \$ | • | • | | |
| Compensation paid: \$ | | | 9 FOR: . | | | en weel |
| BENEFITS ARE PAYABLE D Total/temporary total disa | FRUM | y partial disability | Permanent partial disa | bility of | Part of Body | |
| | . 19 Wł | IEN THE EMPLOYE | E ACTUALLY RETURNS COMPENSATION | RNED TO WORK. I AND THE EMPL | OYEE. | |
| D Total/temporary total disa | THE STATE | BOARD OF WUKUE | - COME ELONIE | | | (Extensio |
| UNTIL FILING OF FORM WC2 W | | | | | V) /* 72 | |
| UNTIL FILING OF FORM WC2 W | 2 | nt Name of Person Fili | | ' YOI THYNI INVER IOF | CONTRACTOR SHALL STATE | WCW 01981 |
| UNTIL FILING OF FORM WC2 W | 2 | nt Name of Person Fili ONTROVERT PAYN | ENT OF COMPEN | A I I O I I I I I | | MCAA 0 190 |
| UNTIL FILING OF FORM WC2 W By (Insurer/Self In | surer: Type or Prin | n Name of Person Fili ONTROVERT PAYN | TENT OF COMPENS | <u> </u> | | CONFIDENT |
| UNTIL FILING OF FORM WC2 W By (Insurer/Self In Henefits will not be paid be | surer: Type or Prin NOTICE TO C | ONTROVERT TATE | | | (Trice | CONFIDENT |

| GEORGIA STATE BOARD OF WORK | ERS' COM | PENSATIO | N | | OSHA File No. | |
|--|---|---------------------------------|-----------------|------------------|--|---|
| | | | | | Insurer File | 100 70791 |
| A EMPLOYER'S FIRST REPORT OF INJUR | Y OR OCC | UPATIONA | | | No. | 678-72396 |
| Employer Phone | No. | Insurer/Self l | | | Crass | 100 T |
| Employer 1346-1 | 184 | Employer FE | IN | | IPA FEIN | |
| POBOCO 105366 | | CV-18 | , 1741A | | Address | 506.554 |
| State/Zip . Nature of Dataset | ss (MIg., In | ide, Transp., | etc.) | | Doc | xx 5095 |
| | | City | | State/Zi | | State/Zip |
| Employer Location Address (II Dities only | | · | | | TPA/Claim | c Office Phone No. |
| Place of Accident or Exposure (Address of Location) | | | | | 1078- | 443-3663 |
| | | | Date of Bit | th | County | h- |
| Employee Name (Last) (First) (Middle) | | <u> 94-</u> | Male Fo | male | Employee | Social Security Number |
| Address | | • | | | 256 | -33-2657 |
| Sq Gold Eagle Dive | ne Pb.# | | Number of I | ependents inc | luding Spouse | DO NOT WRITE IN |
| City | | | | <u> </u> | | THIS COLUMN |
| Time Work | kday Began | | Date Employ | yer Notified | | Insurer No. |
| Date of injury | pm | ا ن | ဥခ | 7-43 | as Paceive Full | SIC |
| Date Hired Dad Employee Work the Next Da | y? Firs | Date Emplo Vork a Full D | aa Aee Lanen | Hay tel. Day | ee Receive Full of Injury? | 1 |
| , | 1 | | _ | ١ | - 11- | Date of Birth |
| 1-93 DYS TNO | | <u>2-28-4</u> | Y Petr | Yes | UTY OF Disease | - Date of Butter |
| Hours Worked | ormaily Sche | qnjeq . | _ | 1 1 | r() Day() | Sex |
| Per Day () 1) Worked Per Off Da | | • | Cont | 002 | k() Mo.() | ┧ ̄ ̄ |
| | <u> </u> | It board. To | dging, or oth | er advantages v | were lumushed, | County of Injury |
| Per Week (COMPLETE WAGE STATEMENT ON REVERSE: It employee is hourly, on commission or piecework basis, enter average weekly am | ount . | enter avera | ge weekly an | iount | | |
| hourly, on commission or precent | | ١. | • | | | Employer Aware |
| \$ | | Type of in | jury/lilness | Part of | Body Affected | |
| S Did Injury/Illness Exposure Occur on Employer's Premises? | | Kos | | 2 1 | <u> </u> | Nature |
| No D | | 1 4 4 4 | رحم | | | ·. |
| How Injury or Illness/Abnormal Health Condition Occurred. | المحادث | | | · · | | Body Part |
| Define Motor Training to Value of the Wage | - 100 | · Lu | Fatal: Give I | ate of Death | | · |
| If Returned to Wark, Give Date | | | | Ti la-1 Olar | me & Address) | Cause |
| Treating Physician (Name and Address) | Initia | Treatment | | Hospital (148) | HE & Addicas | M.O. |
| Treating Thysican C. | □ No | Treatment nor: By Emp | Journ | | | 11.0. |
| O-Czada | loMi | nor: Clinic/H | (Ospital) | | | Controvert |
| Dr Cispela 3280 Howell mill Ra | O En | nergency Care spitalized > 2 | t 4 hrs. | C | نهونهم | D. First |
| 3280 HOWELL WILL | | · - | | | _ | |
| Atlanta Ga 30327 | Position | Yes 0 | Tek | phone Numbe | x | Date of Report |
| Print of Type) | | പ നമ്മ | - 1 /- | - : is | -0 500 C | - 14-1-98 |
| EMPLOYER'S FAILURE TO SUBMIT THE | S REPORT | TO INSUR | ERIMMED | IATELY MA | y result in P | ENALTY |
| | EAD HIST R | IV INSTIRL | 02FFE-F134 | UNCH | | |
| B | 75555 | Date of dist | bility 22 | 248 Date | of first payment: | |
| Weiske meenly and a manual and | <u>ب</u> ٠. | Desciousely | Medical Only | / Yes u | MO 0 | er at with |
| Compensation paid: \$ Penalty paid: \$ | gene. | مبطمست | 2160 | احد عما | bory in 1 | iew of work |
| | | | | | for | weeks |
| DENEFITS ARE PAYABLE FROM OCILATION OF TOTAL ACTION OF TOTAL A | o remand | er caracter and | | % to ALL OTHE | OI BODY R SUSPENSIONS | REQUIRE THE FILING OF |
| O Total/temporary total disability O Temporary partial disability UNTIL FORM WC2 WITH THE STATE BOARD OF WORKERS COM | APENSATION OF THE PROPERTY OF | N AND TH | É EMPLOYE | E | | |
| | 2 | Cra | سعدا | <u>4-294</u> | 18 Mg.4 | (Extension) |
| By Clasurer/Sell Insurer: Type or Print Name of Person | n Filing For | m and Sign) | | (LOBIE) | ddistanct inform | etion) |
| (Insurer/Sell Insurer: Type of Frank Name of Cost | RT PAYME | NT OF COM | MPENSATIO | over for a | AND PROPERTY OF THE PROPERTY O | |
| | | 300 | | Seas Military | - 16-m | 200 - 100 - |
| Benefits will not be paid because: | n hiline has | m and Sum) | | (Date) | (Pho | ne) (Extension) |
| (insurer/Self Insurer: Type or Print Name of Perso | denvine her | refits is a eni | ne subject to | penalties of u | p to \$10,000.00 p | er violation (O.C.G.A. §34-9 |
| By (insurer/Self Insurer: Type or Print Name of Perso Willfully making a false statement for the purpose of obtaining or | Sen I will ner | | | - D 1 4 | ~ A ! | g** (7 |
| and \$34-9-19). | | Ì | NNF | . } [| CAL | |
| | | 1 | IVIL | _レ! | リバト | Usum ! |
| • | | | - | | | |
| | | • | | | | WCW 019821 |
| | | • | | | | CONCIDENTIAL |

MICHAEL CIEPIELA M D 3280 HOWELL MILL RD SUITE 110 ATLANTA GA 30327

Patient:

Name: WALKER, BOBBY

DOB: 9/04/64

Sex: M

SSN: 252-33-2657

Date of Exam: 3/19/98

MRI OF THE RIGHT KNEE:

HISTORY: Injury.

T1 coronal and multi-echo sagittal views of the knee were obtained. 3-D FT acquisitions were also obtained for ViStar manipulation.

The patient had a previous exam here approximately one year prior.

On today's study, there is again evidence of a partial medial meniscectomy as most of the medial meniscus has been removed. As stated in the previous report, the remaining remnant is somewhat irregular but I am unable to definitely substantiate a recurrent tear. The lateral meniscus remains intact.

There is also once again noted to be an absence of the anterior cruciate ligament consistent with a chronic deficiency. The posterior cruciate ligament as well as the patellar and quadriceps tendons appear intact. The medial and lateral collateral ligaments appear unremarkable.

There is no evidence of an acute bone injury as I do not see evidence of a bone bruise or microfracture. Since previous exam the patient has developed several small focal areas of osteosclerosis involving the articular surface of both the medial and lateral femoral condyle.

The predescribed pure chondral fractures involving the posterior

continued:

WCW 019825 CONFIDENTIAL Bobby Walker Page 2

aspects of both the medial and lateral femoral condyles have somewhat healed since previous exams. Evidence of the previous chondral fractures are still seen on image C12, C34. The chondral fractures have healed, however, there is some resultant thinning of the articular cartilage on both the medial and lateral compartments consistent with grade IV chondromalacia. There is an associated joint effusion but I do not see evidence of a Baker's cyst.

IMPRESSION: NO ACUTE ABNORMALITIES HAVE DEVELOPED SINCE STUDY OF ONE YEAR PRIOR. THERE IS EVIDENCE OF AN ALMOST COMPLETE MEDIAL MENISCECTOMY. I DO NOT SEE EVIDENCE OF AN ACUTE MENISCUS TEAR. THERE IS AN ABSENCE OF THE ANTERIOR CRUCIATE LIGAMENT CONSISTENT WITH CHRONIC DEFICIENCY. THE PREVIOUS DESCRIBED CHONDRAL FRACTURES INVOLVING THE POSTERIOR ASPECT OF THE MEDIAL AND LATERAL FEMORAL CONDYLES HAVE ESSENTIALLY HEALED. THERE IS SOME RESULTANT THINNING OF THE ARTICULAR CARTILAGE ON THE MEDIAL AND LATERAL JOINT COMPARTMENTS CONSISTENT WITH GRADE IV CHONDROMALACIA.

Jerry Domescik, M.D.

da D: 3-20-98 T: 3-20-98

| | | | Case 1:00 | -cv-003 <mark>67</mark> | © C | -D | ocument 1 | 02-12 | File | ed 12/1 | W02 | 2 Page | 13 of | 26 | | |
|------------|------------------|-----------------|---------------------------------------|---|------------|--------------|---|----------------------|---------------------|----------------------|------------------|---|---------------------|-----------------|-------------|---|
| | | | | | S | | | • | | | Z _i , | deliner. | " | م نو. | | |
| • | | | · · · · · · · · · · · · · · · · · · · | | | | | | | ord AM | | SANS! | ٠ | X | 1/1 | |
| PLE | ASE | | | | | | | CR WC | AME. | | الحالف | A PARTY NAMED IN COLUMN TO A | 1 | ASSE | 102 | 74 |
| DO | NOT | | | | | | | PO | BO | X 520 | 67 303 | 55 006 | | 18/2/ | | _ |
| | THÌS REA | | 7 | | : | | | ГA | LAN | ITA GA Hinsurance | | | | の意思 | PAM IN IT | |
| · | • | | | | _ | | | FECA . | IEALT | OTHER I 12 INS | NUED. 2 | ITT IACIMAS | China | GR PROX | (A | |
| → □ | | | F MEDICAID | CHAMPUS | | HAMP | 10000 | WI BLK LUI | | . 1 - | | 32657 NAME (Last Name | e, First Nam | - 144 | 7 000 | |
| 15 | - | DICAR | | (Spanear's SS) | "1 L | W F34 | 3 PATIENT'S BIRTH | DATE | SEX] .[| 11 6 | nME | • | | | w | |
| 8 2 2 | PATIE | พร | NAME (Last Name, Fi | ret Name, Middle Initial | , _ | | 09 04 | | URED | 7. INS | URED'S | ADDRESS (No. | Speet | | | |
| × | W | ALI | KER BOBB' ADDRESS (No., Sue | 1 13 et) | | | Self XSoos | 11 | Othe | | AMI | <u> </u> | | | STAT | E |
| TYPING | ر. المارة الم | 9 | GLENEAGL | E DR | | STAT | 7. | | 1 | CITY | | | - 1971 26 | HONE (Include | Area Code | , |
| £ | CHY | | | ٠, | • | | 3/A Single | harried | Other | 250 | ODE | | TECEP! |) | | |
| ALIGN BY | ZIP C | 'AY | ETEVILLE | 1 . | | | Employed | Full-Time Student | Part-Tim Student | 1 | SEI IRF | D'S POLICY, GRO | OUP OR FEC | A NUMBER | | |
| | | | 14 | (770 71 | 6 68 | 34 | IQ IS PATIENTS | CONDITION RE | LATED T | · 1 | WCW | 7 | | | | |
| | 9.01 | HER | NSURED'S NAME (L | sal Name, First Name, | | | a EMPLOYMEN | TO ICURRENT O | R PREV | nousi a.# | VSUREC | S DATE OF BER | H Y | м | SEX F | |
| | . 0 | NA HER | NSURED'S POLICY | OR GROUP NUMBER | | | a Employmen | X YES | lw. | ļ, | UPLO | ER'S NAME OR | SCHOOL N | AME | | |
| • | 1 | | INSURED'S DATE OF | | EX | | B. AUTO ACCID | YES Y | X NO | ADE 10000 | | NCE PLAN NAM | | | | |
| | M | м, | 1 | M 1_ | <u>. f</u> | 丄 | a OTHER ACC | | <u> </u> | | | MACOURT. | DΝΔ | COWEST | 1 <u>Y</u> | |
| | c. E | MPLC | YER'S NAME OR SC | HOOL NAME | : | | | YES N | XNO | | IS THE | RE ANOTHER H | WINDOW | | | em 9 a- |
| | | | ANCE PLAN NAME | | | . | 10d. RESERVE | D FOR LOCAL | | 1 | | YES AND | | , return to and | | |
| • | d. | | | | | OME | FING & SIGN | ING THIS F | ORM. | to process | raedi | CE DELENS | | | | 30 |
| | + | | | | | | ease of any medical or of all or to the party who ac | capts assignment | 66low. 98 | | : | SIGNATU | RE O | M EILE | | |
| : | 15 | 2. PATI this | claim. I also request par STGNA | TURE ON | FILE | • | | | | | SIG | NED | BLE TO WO | ORK IN CURRE | NT OCCUI | PATION |
| | - 1 | SK | NEO | AILLNESS (First sym | | | 15. IF PATIENT HU GIVE FIRST D | S HAD SAME O | A SIMIL | AR ILLNESS. | 1 | Maries 5 | . 1 | . 10 | | · |
| • . | | • | TE OF CURRENT: | INJURY (ACCIDENT | 7 | | 17a LD NUMBER | | G PHYS | CIAN | 1 | SPITALIZATION T | ATES REL | M TO | M DD | 1 |
| • | ŀ | 17. N | ME OF REFERRING | PHYSICIAN OR OTHE | R SOURC | E | | | <u>.</u> | | FROM 20. O | UTSIDE LAB? | | RECE | #VE | DR |
| • | ١ | ŀ | | | | | \ | | | | 1 T | YES | NO | · · · · | | 1448 |
| | | 19. F | ESERVED FOR LOCA | | | STE I | TENS 123 OR 4 TO | ITEM 24E BY U | NE) | 1 | | REDICAID RESUB | . 1 . | ORIGINS REF | 8 0 | 1000 |
| • | | 21.1 | DIAGNOSIS OR NATU | RE OF ILINESS OR IN | MONTA OUR | -Luc | | | | ▼ . | 23.1 | PRIOR AUTHORIC | ATION NUM | IBER | 1/ Cl | ALS |
| | | ١. | 844 2 | • | | | • • | | | • | | | 101 | K & | <u> </u> | Page K |
| • | | ١. | • | | - B - T | c T | 4 | 00 0100 | UES | E | + | S CHARGES | DAYS OR UNITS | Family EMG | 990 | RESERV |
| | | 24 | DATE(S) OF | SERVICE | a | Type | PROCEDURES, SERV (Explain Unusual CPT/HCPCS] N | Circumstances) | | CODE | + | 40 0 | | | 1/8 | |
| | | 1 | M DD YY | MM DD YY | - | 7 | 97110 | | | 844.2 | + | | _ | 11/ | 1 10 | |
| | | | 07 30 98 | 07 30 98 | 1 | | 00000 | | _ <u>.</u> | 844.2 | | 45 C | 0 1 | 12 - | Pla | |
| | | 1 | 07 30 98 | 07 30 98 | 11 | 1 | 97112 | l | | 844.2 | 丁 | 48 | 00 1 | W | | <u>.</u> |
| | • | 2 | | 20: 00 | 3 11 | 1 | 97530 | | : 2 | 844.2 | - | | _ | | I | 135 |
| | | | 07 30 98 | 01/30/3 | + | - | | <u>'</u> | |] _ | _ ;}: | | | 1 1 | 170 | |
| | | 1 | | 1 1 | | | | | | | | WC | W 019 | 9725 NTIAL | 7 | _ |
| | | -4 | | , , | 1 | | 11 | | | | | - CON | ישטואו | NTIAL | 1 | V |
| | | 4 | | | +- | 十 | 33 | | . : | <u> </u> | í, | 28. TOTAL CHA | RGE | 29. AMOUNT | PAID | 30. BAL |
| • | | • | 1 1 | 1_1_1_ | SN EW | 1 12 | PATIENT'S ACCOUN | TNO. | 7. ACC | EPT ASSIGNME | beck) | | | 3 | OL OC | ZIP COOE |
| | | | 25. FEDERAL TAX I | 7697 [| T * | | | | WHEN Y | E SERVICES W | ERE | 33. PHYSICIAN | | | | |
| | | | 58 215 | DELASIVATE ALL ALL | UEA NLS | | | | | | | 3280 | HOM | • | | |
| | | | | GREES OR CREDENT is statements on the re are made a part thereo | | " | SOON WOW | /PLL 1714 | | אט אי | | ATLA | NTA | GA | .052 | |
| | | • | ROSS BRA | KEVILLE P | T | ۱ ۾ | ATLANTA | GH 302 | ! | _ = | | PIN + | | FORM | P # | 0 (U2) (12- 00 FO -0938-000 |
| | | | CR 253 | 6 00 (| 04 9 | | | PLEAS | E PR | INT OR TY | PE | = = = . | | APPRO | VED OMB | .ó93 8-0 00 |
| | | | Signed | DV ANA COUNCIL OF | 4 MEDICA | L SER | VCE 15/801 | | | | | | | | | |

CRAWFORD AND COMPANY PLEASE **WCW** PO BOX 52067 DO NOT ATLANTA GA 30355 0067 STAFLE PICATT IN THIS HEALTH INSURANCE CLAIM FORM (FOR PROGRAM IN ITEM 1 AREA OTHER | 14 INSURED'S LO. NUMBER FECA BLK LUNG (SSN) GROUP HEALTH PLAN (SSN O' 10) 252332657 INSURED'S NAME (Last Name, First Name, Middle Initial) PICA CHAMPUS MEDICAID MEDICARE (VA File *) (Sponsor's SSN) TIENT S BITTH DATE [Medicald +] SAME 2. PATIENT'S NAME (Last Name, First Name, Microle Initial) 09 04 64M . INSURED'S ADDRESS (No., Seed) WALKER BOBBY L. S. PATIENT'S ADDRESS (No., Street) STATE SAME CITY 59 GLENEAGLE DR ente ELEPHONE (Include Area Coce) 70 CODE GP FAYETEVILLE 11. INSURED'S POLICY, GROUP OR FECA NUMBER TELEPHONE (Include An Employed Suded Suded 770 716 6834 9. OTHER INSURED'S NAME (Last Nama, First Name, Midd WCW SEX a INSURED'S DATE OF BIRTH . EMPLOYMENT? (CURRENT OR PREVIOUS) MM DD I YY NA . OTHER INSURED'S POLICY OR GROUP NUMBER D. EMPLOYER'S NAME OR SCHOOL NAME X YES PLACE (State AUTO ACCIDENTY c. Insurance plan name or program name b. OTHER INSURED'S DATE OF BIRTH SEX X NO L YES CRAWFORD AND COMPANY MM , DD ; C OTHER ACCIDENTY A IS THERE ANOTHER HEALTH BENEFIT PLAN? C. EMPLOYER'S NAME OR SCHOOL NAME YES YES NO R yes, return to and complete tiem 9 a-13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment 10d. RESERVED FOR LOCAL USE d. INSURANCE PLAN NAME OR PROGRAM NAME medical parality to the nuclearized bylancian or ambiliar for services desc. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I mathematics the release of any medical or other information necessary this claim. I also recurst payment of government below.

7 28 98 SIGNATURE ON FILE SIGNATURE ON FILE 7 28 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY TO 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FRIST DATE MM DO YY 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY LLNESS (First symptom) OR MUJRY (Accident) OR PREGNANCY (LMP) 14. DATE OF CURRENT: 174 LO. NUMBER OF REFERRING PHYSICIAN RÉCEIVED B 17. NAME OF REFERRING PHYSICIAN OR OTHER BOURCE 20. OUTSIDE LAB? YES XHO 22. MEDICAID RESUBMISSION ORIGINAS REFONO 8 1998 19. RESERVED FOR LOCAL USE 21. DIAGNOSIS OR NATURE OF ILINESS OR WILLIRY, (RELITE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 23. PRIOR AUTHORIZATION NUMBER 844 2 G H EPSOT Family Plan RESERV: COB EMG PROCEDURES, SERVICES, OR SUPPLIES \$ CHARGES DIAGNOSIS DATE(S) OF SERVICE (Exotain Unusual Circumst CPT/HCPCS | MODIFIER Type CODE Place 24. 40:00 844.2 97110 MM DO 1 07| 28| 98| 07| 28| 98 11 45! 00 844.2 97112 1 11 07| 28| 98 28: 98 48 00 844.2 97530 1 11 98 07: 281 281 98 071 WCW 019726 CONFIDENTIAL 29. AMOUNT PAID 30. BALF 28. TOTAL CHARGE 27. ACCEPT ASSIGNMENT? of ods 133 00 5 32 NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE REPORTED IN other transforms or office) 28. PATIENT'S ACCOUNT NO. 33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE SSN EN 6 25. FEDERAL TAX LD. NUMBER ATLANTA SPINE AND REHA! 58 2157687 3280 HOWELL MILL RD S 31. SIGNATURE OF PHYSICIAN OR SUPPLIER
NOLLIDING DEGREES OR CREDENTIALS
(I certify that the statements on the reverse
to this bill and are made a part thereof.) ASRC INTEGRA 3280 HOWELL MILL RD St GA 30327 ATLANTA ATLANTA GA 30327 FORM HCFA-1500 (U2) 112-FORM OWCP-1500 FOR APPROVED OMB-0938-000 ROSS BRAKEVILLE PT

PLEASE PRINT OR TYPE

98

WAY COUNCIL ON MEDICAL SERVICE 12/901

08 <u>Q4</u>

sic 2536

| Case 1:0 | 00-cv-00367-CC Document 102-12 Filed 12/17/02 Page 15 of 26 |
|-----------------|--|
| nerapist | □PT □OT □ SLP □ Psych |
| reatment/Dx Cod | |
| Date | Chros DONG DIL T. PROPERSION SLOWLY T. P. STRONGER |
| | Roli-1-2' Bolit V 3 E CHOUND END FED 410 Stanott: KNTK = 40 (L) 18 (P) 10 KNES V = 60 (L) 8 (P) 10 PEROSTRIPIOS 20 SEC (L) 16 (P) 12 Thin LAT. KNES SLID |
| | Résident à ADDITION DE REPORT DE LA REPORT DE LA PROPERTE LA PROPERTE LA PROPERTE PAR REPORT DE LA REPORT DE LA PROPERTE PAR LA PROPERTE PAR REPORT DE LA PORTE DE LA PROPERTE PAR REPORT DE LA PROPERTE PAR REPORT DE LA PORTE PAR REPORT DE LA PROPERTE PAR REPORT DE LA PORTE |
| 4.30.98 | Pet 278 96 P NO V WILL STATE TOOK LONG HER |
| | |
| | |
| | |
| | |
| | |

WCW 019727 CONFIDENTIAL

GARED 2 5 3 6 07 1 1 SATE 98 | CAPPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

25 FEDERAL TAX LD. NUMBER

58 2157687

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS

ROSS BRAKEVILLE PT

(I carily that the statements on the reverse apply to this bit and are made a part thereof.)

PLEASE PRINT OR TYPE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WER

3280 HOWELL MILL RD ST

26. PATIENT'S ACCOUNT NO.

ASRC INTEGRA

ATLANTA GA 30327

27. ACCEPT ASSIGNMENT? (For govs. claims, see back

YES NO

FORM MCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500 430144 — Medical Arts Press

29. AMGUNT PAID

ATLANTA SPINE AND REHAB CTR 3280 HOWELL MILL RD SUITE 1

GA 30327

GRP#

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE

\$

28. TOTAL CHARGE

ATLANTA

133 00

30. BALANCE DUE

0 00 | 133 00

| Therapist | | | | Patient Name | 3. War | v. |
|-----------------|---|--|----------------------------|--------------------|----------|--|
| Physician | | · · · · · · · · · · · · · · · · · · · | PT | 🗆 от | □ SLP | ☐ Psych |
| Freatment/Dx Co | de(s) | | <u> </u> | | | |
| Date | | | Progress | | 75 E 1 | by Ht |
| 6.4.98 | SHAB C SHUATS. FON P. FRISHER PLAN TO | Now - the | plate. of | | CLE talk | |
| 6.8.98 | GARES PRISHER CENT OF SWILL | | WELL ACT E 1 OHGRES. | أبر الحماء ال | y vatic | WK 11-12 |
| 6-16-98 | N V | Dipe Africal African A | Suffer & | Plojeto Plojeto | | interrity |
| b 23.98 | Pr states | SHIPS & | V idless | | PANN 13 | PPA 2000 100 MCM 010120 MCM 01012 |
| (a/30 | No c/o, | onin, con | Him Al | Neet. | rad. | Mest 3/1) |
| 7-14-93 | 1948 7.10 1904 + 1908 I | 1- WAS WORLD 23 (2) KNEE 115°. 115°. | PRISHOST E | Systems 1 | AU SULFO | |

| | | | . 6 | CDI | WEORD A | ND COMPANY | | | | | 25 |
|--|---------------------------|--------------|--|---------------|---|--|----------------------------------|-------------------------|-------------------|-----------------|--|
| | | | | WCV | n . | | | | | | CARRIER |
| | | | | | BOX 52 LANTA GA | 2067 X 30355 006 | 57 | | | | S |
| | | | | | | NCE CLAIM FORM | | | | | PICA |
| PCA | | CH | MPVA GROUP | FECA | OTHER 1a | INSUREO'S LD. NUMBER | | | (FOR I | PROGR | AM IN ITEM 1) |
| DICARE MEDICAID CHAMPUS | | | File 4) HEALTH PLAN | (SSN) | (10) | 252332657 | ame, Firs | Name. | Middle I | mitial) | |
| NT'S NAME (Last Name, First Name, Middle | | | 3. PATIENTS BIRTH O | 4 M X | | SAME | | | | | |
| LKER BOBBY L NT'S ADDRESS (No. Street) | | | 8. PATIENT RELATION | ISHIP TO INSU | RED 7 | INSURED'S ADDRESS IN | o" 2fieer | , | | | |
| GLENEAGLE DR | | | Sell X Spouse | Child | Other | SAME | | | | | STATE |
| | | s | | terried | Other | | TE | LEPHO | NE (Inci | ude Are | STATE STATE |
| YETEVILLE | clude Art | e Code | | | ,[| IN CODE | | (|) | | |
| 0214 (770)7 | 16 | 6834 | Employed S | NOTION REL | Sucert AJED TO: | 11. INSURED'S POLICY, G | OUP OF | FECA | NUMBE | A | |
| IER INSURED'S NAME (Last Name, First Na | ne, Middle | e initial) | | | 1 | WCW | ETH | | | SE | · |
| A HER INSURED'S POLICY OR GROUP NUMB | ER | | a. EMPLOYMENT? | | PREVIOUSI NO | MM ; DD ; | YY | | M. |] " | ^ - |
| · | | | L AUTO ACCIDENT | YES | PLACE (State) | & EMPLOYER'S NAME OF | SCHOO | X, NAM | E . | | |
| HER INSURED'S DATE OF BIRTH | SEX F | | | YES X |]∞ | C. INSURANCE PLAN NAM | E OR PF | OGRAL | A NAME | | |
| PLOYER'S NAME OR SCHOOL NAME | <u></u> | <u></u> | C. OTHER ACCIDEN | YES X |]NO | CRAWFORD | AND | CO | MPA | NY | |
| | E | | 10d. RESERVED FO | L | | d. IS THERE ANOTHER H | EALTH B | ENEFIT | PLANT | | Daris () B/(|
| SURANCE PLAN NAME OR PROGRAM NAM | | | | | _/_ | YES X NO | _ | | A4004671 | IDE Laur | plete Rem 9 a-d. |
| READ BACK OF FORM E PATIENT'S OR AUTHORIZED PERSON'S SIGNATI | EFOR | E CON | IPLETING & SIGNING | THIS FOR | IM. | medical benefits to the | NICHENDIN | an bulanc | | | |
| PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE this claim. I also request payment of government is SIGNATURE ON | HE I MUN | her to my | set or to the party who accepts | 9 80 | 8 | SIGNATU | RE C | ON E | 'lli | | 9 00 30 |
| | | | | | | 16. DATES PATIENT UN | BLE TO | WORK | N CUR | RENT O | CCUPATION D D 1 Y Y |
| DATE OF CURRENT: ILLNESS IFFIX R NJURY (Acciden | a) Un | OR | 15. IF PATIENT HAS HA | MM DO | YY | GRUM MM DD | 1 ' | | 70 | | |
| NAME OF REFERRING PHYSICIAN OR OTHER | MPI | RCE | 178. I.D. NUMBER OF | REFERRING PI | HYSICIAN | 18. HOSPITALIZATION D | ATES RE | LATED | TO CUH A TO | AM ; | OO YY |
| , NAME OF REFERENCE PRODUCTION | | | \ | \ | | FROM 20. OUTSIDE LAB? | ' | | S CHAR | GE9 | |
| RESERVED FOR LOCAL USE | | | | | · · | YES X | | | | | <u> </u> |
| 1, DIAGNOSIS OR NATURE OF ILLNESS OR | NJURY. I | RELATE | TEMS 1,2,3 OR 4 TO TIEM | 24E BY LINE | | 22. MEDICAID RESUBA | MSSIUM | ORIGI | NAL RE | F. NO. | |
| 844 2 | | | 3 | | | 23. PRIOR AUTHORIZA | N MOIT | MBEA | | | |
| 1 | | | 4 | | _ | | 16 | н | | <u>.</u> | K |
| | B | C Type | D | OR SUPPLIES | DIAGNOSIS | S CHARGES | DAYS OR UNITS | EPSOT Family Plan | EMG | COB | RESERVED FOR LOCAL USE |
| 4. A | | | | | | 1 - | PAULS | 1.000 | | | |
| DATE(S) OF SERVICE | of Service | Service | CPT/HCPCS MODIFIE | :R | CODE | 40 00 | 1 | | | | |
| A DATE(S) OF SERVICE FROM DD YY MM DD YY | of | Service 1 | 97110 | | 844.2 | 40 00 | +- | | | 757 | h_ |
| 4. A DATE(S) OF SERVICE OF SERVIC | Service 11 | 1 | 97110 | :X | 1 | 40 00 | 1 | | | 200 | Elva |
| 4. A POTE (S) OF SERVICE WM DD YY MM DD YY MM DD YY MM DD YY MM DD YY 09 08 198 | Service 11 | | | | 844.2 | | +- | | | C. | EIVED |
| 4. A POTE (S) OF SERVICE MM DD YY 09 08 198 | Service 11 | 1 | 97110 | | 844.2 | | +- | 7 | | CI | EIVED. |
| A. A PATE(S) OF SERVICE PROMISE OF 198 98 98 98 98 98 98 98 | Service 11 | 1 | 97110 | | 844.2 | | +- | 7 | e _A | CY | EIVED 05 1998 |
| MM DD YY MM DD YY 09 08 98 09 08 98 | Service 11 | 1 | 97110 | | 844.2 | | +- | A | e ₄ | CY | EIVED 05 1998 |
| MM DD YY MM DD YY 09 08 98 09 08 98 | Service 11 | 1 | 97110 | | 844.2 | 45 00 | +- | A | e _A | CY | EIVED 05 1998 AINS |
| A. A PATE(S) OF SERVICE PROMISE OF 198 98 98 98 98 98 98 98 | Service 11 | 1 | 97110 | | 844.2 | 45 00 | 1 | - | 14 | CZ | S 1998 AIMS |
| 98 98 98 98 98 98 98 98 | Service 11 | 1 | 97110 | 27. 160 | 844.2 844.2 | 45 00 | 1 | 29. AM | IOUNT F | CZ | SO BALANCE OU S 85 |
| A. A PATE(S) OF SERVICE FROM 10 YY MM DD YN M DD Y | Service 11 11 11 X | 1 1 26. | 97110 | 27. ACC | 844.2 844.2 EPI ASSIGNAEN SON COMMIL SEN SON COMMIL SEN SON NO | 45 00 | 1 | 29. AM S | O NAME | C | 30. BALANCE DU S 85 3. ZP CODE & PHONE |
| A. A PROMISE OF SERVICE FROM DD YY MM DD YN DY | Service 11 11 11 X | 26. | 97110 3 97112 4 PATIENT'S ACCOUNT NO. NAME AND ADDRESS OF FREND'S REPORTED IN THE CARE AND ADDRESS OF FREND'S REPORTED IN THE CARE AND | 27. ACI | 844.2 844.2 SEPT ASSIGNMENT FROM COMME SERVICES WEF | 28. TOTAL CHARGE S 85 TE 33. PHYSICIANS SI | 1 100 POERS | 29. AM S BILLING | NOUNT F | ALD CONTESSIVID | 30. BALANCE DU S 85 A ZEF COOR & PHONE REHAB CT |
| PROPERTY OF SERVICE FROM DD YY MM DD YN M D | Service 11 11 11 XX ER US | 1 1 26. 32 P | 97110 97112 | ACLITY WHEE | 844.2 844.2 SEPT ASSIGNMENT FROM COMME SERVICES WEF | 45 00 | 1 00 FUERS A SI OWEI | SHUMG | NOUNT F | C OOMES | 30. BALANCE DU S 85 A ZEF COOR & PHONE REHAB CT |

| Case-1:00-cv-003 | 8 <mark>67-</mark> CC | Docun | nent 102 | -12 Filed | 12/17/6 |)2- -P | age | 19 of | 26 | * * | |
|---|-----------------------|--|--|-------------------------|-------------------------------------|-------------------|-------------|-------------------------------|-----------------------------|---|----------------|
| ASE NOT | | | | AWFORD A | ND COME | YNA | | | | | NER- |
| IPLE ITHIS | : | | WC PO AT | BOX 52 LANTA GA | 067 30355 | 0067 | | | | | -CARRIE |
| 1. | | | | HEALTH INSURA | NCE CLAIM FO | RM | | (FOF | PROGR | PICA () | X |
| MEDICARE MEDICAID CHAMPUS | CHAMP ON FR | HEALTH | I PLANT BUX III | MG (ID) | . INSURED'S LO. N 2523326 | 57 | | | | | |
| (Medicare e) (Medicaid e) (Sponsor's SSN) ATIENT'S NAME (Last Name, First Name, Middle Initial) | 1 1,44,14 | 3 PATIENT S BI | RTH DATE | | INSURED'S NAME SAME | (Last Name | e, First Na | uma, Middle |) linkian) | | |
| WALKER BOBBY L | | 6. PATIENT REL | ATIONSHIP TO INS | JREO 7. | INSUREO'S AODR | ESS (No., S | Street) | | | | N _C |
| PATIENT'S ADDRESS INC., Street) 59 GLENEAGLE DR | | | Cried | 1 | SAME | | | · | | STATE | M |
| Y | STATE GA | 8. PATIENT STA | Married | Other | | | THEIR | PHONE (Inc | -tude Are | a Code) | INFORMATIO |
| FAYETEVILLE | | 1 - | Full-Trace | Part Time | IP CODE | | (|) | | | NZ. |
| 30214 (770)716 OTHER INSURED'S NAME (Last Name, First Name, Mid | | 10. IS PATIENT | Student I'S CONDITION REL | ATED TO: | 1. INSURED'S PO | LICY, GROU | P OR FE | CA NUMBI | ER | | JĒ |
| NIA | | | NT7 (CURRENT OF | PREVIOUS) | WCW INSURED'S DATE | OF BIRTH | , | <u> </u> | SE | × | |
| OTHER INSURED'S POLICY OR GROUP NUMBER | |] [3 | YES | NO | EMPLOYER'S N | į | | ME AME | | F) | AND INSURED |
| OTHER WISURED'S DATE OF BIRTH SEX | <u>-</u> | b. AUTO ACCI | DENT? | 740 | | | | | | | |
| EMPLOYER'S NAME OR SCHOOL NAME | <u>'l</u> l | - OTHER I | | JNO | CRAWFO | nname o RD Al | ND C | :OMPA | YN | | PATIENT |
| : INSURANCE PLAN NAME OR PROGRAM NAME | | 10d. RESERV | YES A | | LIS THERE AND | THER HEAL | TH BENE | FIT PLAN? | | | PAT |
| | | | INIO TUIE FOR | <u> </u> | YES YES OF | AUTHORIZE | A APREA | PO CICAMT | 106 I aud | lete item 9 a-d. sorize payment of services described | \dashv |
| READ BACK OF FORM BEFOR | RE COMPLI | ETING & SIGN e of any medical or s y us the party who ac | (ING THIS FUR other information section coppig assignment back | in. Issay to process | medical benefits below. SIGNA | | | | | 10 98 | |
| 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE 1 authorized baseline claum. I also request payment of government benefits a SIGNATURE ON FILE | E | DA | 9 10 2 | 8 | SIGNED | | | | | | <u>_</u> ' |
| SIGNED | OR | | S HAD SAME OR S | MILAR ILLNESS. YY | 16. DATES PATIEI M M 1 | T UNABLE | TO WOR | TO NE CURI | RENT OC | CUPATION D Y Y | 1 |
| MM DO YY NJURY (Accident) OR PREGNANCY (LMP) | | | OF REFERAING PI | IYSICIAN | 18 HOSPITALIZA | TION DATE: | RELATE | ED TO CUF | RENT S | ERVICES D D , Y Y | \neg |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOL | | | | | FROM 20. OUTSIDE LA | | - | TO \$ CHAR | IGES | ! | |
| 19. RESERVED FOR LOCAL USE | | | | | YES | XΝο | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. | RELATE ITEM | \$ 1,2,3 OR 4 TO II | TEM 24E BY LINE) | — | 22. MEDICAID R | EZUBMISSI | OR | IGINAL RE | F. NO. | | |
| 844 2 | | 3 | | • | 23. PRIOR AUTI | ORIZATION | NUMBE | A | | | |
| 2.1 | | 4 L | | . | | | | | J | K | |
| 24. A PACE PACE PACE | | EDURES, SERVIC Explain Unusual C | | DIAGNOSIS | S CHARGE | S DA O UN | YS EPSI | EMG | 88 | RESERVED FO | ж —— |
| MM DO YY MM OD YY Service 09:10:98 09:10:98 11 | Service CPT | 7110 | 1 | 844.2 | 40 | 00 | 1 | | 15 | CEH | |
| 09 10 150 65 1-1 | 1 9 | 7112 | ! | 844.2 | 45 | 00 | 1 | | a_{c} | CEIVEL | D E |
| 09 10 98 09 10 98 11 | | | <u>.</u> | 844.2 | 48 | 00 | 1 | 4. | - | | _ |
| 09 10 98 09 10 98 11 | 1 9 | 7530 | | 244.6 | + | - | + | - 17-€ | 4 | 1990 LAIMS | |
| 3 | | | 1 | · | <u> </u> | | _ - | | - | SAIM | <u>~</u> |
| 4 | | 1 | | 1 | 1 | | | | | | ر |
| 5 | + + | | | 1 | | | T | | | | - نـــــــ |
| SSN EN | 128. PATIE | IT'S ACCOUNT NO | j 5. 27. ACC | PT ASSIGNMENT? | 26. TOTAL CI | | 1 | A TAUCIA O | 100 | 30. BALANCE C | UE LOC |
| 58 2157687 | | | Y YE | | 1 | 33 00 | DE DE LO | G NAME. A | DORESS. | ZIP CODE & PHON | Œ · |
| 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply | l n eftig | EREY NOTEGI | RA TO COLOR | | ATLA | ATN WOH | SPIN | e an | ID K | EHAD C | rv. |
| to this bill and are made a pert thereof.) | 13280 |) HOWELI UNTA GA | C WILL K | ט צו | ATLA | | GA | 303 | 27 | | |
| ROSS BRAKEVILLE PT GA_2536 09 18 98 | ATM | AITU OU | | | PIN # | | | GRP - | 4 1000 | (12) (12-90) | . · |
| SIGNED | SERVICE 12/9 | <u> </u> | PLEASE PRIN | IT OR TYPE | | | F | ORM HCF ORM OW APPROVED | A- 1500 CP-1500 OMB-0 | (U2) (12-90) FORM RRE 938-0008 | 1500 CF |

| | | | • | Patient Name | BOBBY 4 | IALFER |
|----------------|---------|--------------|--------|--------------|---------|------------------------------------|
| Therapist | | - | □ PT | 🗆 от | □ slP | ☐ Psych |
| Treatment/Dx (| Code(s) | | | | | |
| | | | | ess Notes | | |
| Date 9-10-98 | | NG JOÑE | (-) Up | | For Dic | 782 |
| | | | | | Ke | RECEIVED UCTOS 1999 K CLAIMS |
| | | | | | | WCW 019732 |

| Lifetime Authorit : wn | Medicare Number |
|--|--|
| I request that payment of surborized, inedicare, Medicald, or private i request that payment of surborized, inedical Resources, Inc., for any insurance benefits be made to Georgia Medical Resources, Inc., I authorize any service furnished me by Georgia Medical Resources, Inc., I authorize any service furnished me by Georgia bout me to release to the Health | Name of Beneficiary Pobby Walker RENEFICIARY'S SIGNATURE: |
| holder of medical or cities and its agents, CHAMPUS and its agents, | BENEFICIARY'S SIGNATURE: (OR AUTHORIZED CAREGIVER IF BENEFICIARY UNABLE TO SIGN) X |
| or any private insurance company any information needed to determine these benefits or benefits for related services. I understand that I am responsible for payment of all deductible and co-insurance charges. | IF BENEFICIARY CANNOT SIGN FORM. PLEASE STATE REASON WHY: |
| SEND PAYMENTS TO: Georgia Medical Resources, Inc. | AUTHORIZED CAREGIVER'S RELATIONSHIP TO BENEFICIARY: |
| 718 CHEROKEE STREET MARIETTA, GA 30060 (404) 428-5445 | DATE: 3 28 98 |
| *MAIVER OF LIABILITY *Medicare will only pay for services that it determines to be 'reasonable and necessary' under Section 1862 (a) (1) of the Medicare Law. If Medicare determines that a particular service, although it would otherwise be covered, is 'not reasonable and necessary' under Medicare program standards, Medicare will deny payment for that service. I believe that, in your case, Medicare is likely to deny payment for (specify particular service(s)) for the following reasons: | I acknowledge that this form is subject to all of the terms set forth on the reverse side, which terms are hereby incorporated by reference, and reverse side, which terms are hereby incorporated by reference, and made a part of this agreement between Georgie Medical Resources, inc. made a part of this agreement between Georgie Medical Resources, inc. and myself. I further scknowledge that I have read and understand all of the terms appearing above and on the reverse side. INCLUDING of the terms appearing above and the USE OF EQUIPMENT AND THE DISCLAIMER OF WARRANTIES and the USE OF EQUIPMENT AND SUPPLIES, and that I have received a complete copy of this form. I have inspected and found the equipment above to be in good working order. I have been instructed in the use of this equipment. |
| "I have been notified by my physician/supplier that he or she believes that, in my case, Medicare is likely to deny payment for the services identified above, for the reasons stated. If Medicare denies payment, I agree to be personally and fully responsible for payment. Signed, " | X C POUL PT THERAPIST SIGNATURE X BALL JULE TO THE |
| Beneficiary signature Date | PATIENT'S SIGNATURE |
| CERTIFICATE OF M | IEDICAL NECESSITY |
| 111 Own Bold | 0.0.B. 9/4/104 Sex M S.S. # 2.52-33-216 |
| Patient Name Watter Policy | |
| Patient Address 39 Gleneage 1111 | |
| Insurance Carrier Hay H. Tosucance | State_GR Zip 302\APolicy#RECEIVED BY |
| Address | Zip Phone # JUL 1 3 1998 |
| CityState | Ma) |
| / Diagnosis (R) know ACL repair (Sles | Length of need 3 to 4 mins. |
| Prognosis: Good Fair Guar | uired by your patient for use at home. Please provide the information requested |
| sign, date where amounts are return to our transmission. | • |
| () Cane Adj. FX with tip - Patient's condition impairs ambulation | () Cane Quad Patient's condition impairs ambulation () Walker Folding Patient's condition impairs ambulation |
| () Commode Chair - Patient confined to single room or level of home () Walker Rightform Attachment - Upper body weakness | - walker is for therapy () Wheel Attachment Walker – Upper body weakness left side |
| The second secon | () Other |
| () Crutch - Patient's condition impairs arribulation I, the undersigned, certify that the above prescribed equipment is medical preasonable and necessary in reference to accepted standards of medical prequipment. PHYSICAN INFORMATION: | ally necessary for this patient's well being. In my opinion, the equipment is be ractice in treatment of this patient's condition and is not prescribed as convenien |
| Name Dr. Cipich, Michael Signature | |
| Address 3280 Howell Mill Rd. Ste. 110 A | Hanta GA 30327 WCW 01973 |

World Championship Wrestling

History and Physical Examination Record for License as a Wrestler ☐ First application for license ☐ Renewal application STATEMENT OF APPLICANT 1. LEGAL NAME DATE OF APPLICATION <u> Barri</u> VIAITER ADDRESS (Street, City, State, ZIP) DATE OF BIRTH RING NAME OTHER STATES IN WHICH LICENSED TO OFFICIATE **PROFESSIONALLY** - 6666110F 2. Have you ever served in the U.S. Armed Forces? ... IV.C. D'No D Yes* If you received a medical discharge, state reason: 3. Do you suffer from headaches, blurred or defective vision, dizziness or impaired memory?..... E No D Yes 4. Do you suffer from shortness of breath, pounding (palpitation) of the heart, any pain or pressure in the chest, D No D Yes or have you ever been told that you had any disease of the heart?..... D'No D Yes* 5. Have you ever spat blood, or been told that you had any disease of the lungs?............................... 6. Have you ever been advised to have any special examinations such as x-rays, electrocardiogram, B-No D Yes electroencephalogram, blood examination, etc...... ENO Pres 7. Have you ever fractured any bones, or suffered any back, neck or other injuries?..... I No Yes 8. Have you had illnesses, diseases, accidents, or surgical operations within the past five years?..... 9. Have you any other information concerning your health, past or present, which is not covered by the above DUNG D Yes LINEE Repaired - April 98 - ACL repair I hereby certify that to the best of my knowledge and belief the above statements are true and correct, and realize that any deliberate misstatement will subject me to disciplinary action I hereby authorize WCW, Inc. in writing or verbally to receive and/or discuss and/or disclose to any state athletic commission or other governmental regulatory authority or any third party on a "need to know basis copies of any and all of my licensing, medical and/or hospital records or other information. This authorization shall remain in effect until you receive written notice of revocation by me, which revocation cannot and will not apply to any and all licensing, medical and/or hospital records or information requested, received and/or disseminated by WCW prior to actual receipt of such written revocation. Finally, a photocopy of this authorization shall be deemed to have the same effect as this original. I hereby give my consent to have hypliged tested fof HIV syndrome and any other bloodwork deemed necessary by the physician. Signature of Applicant Signature of Physician PHYSICAL EXAMINATION Temp. (Oral) Weight 1. Height React to light and accommodation 2. Eves: Pupils, Regular Conjunctivae, Right eye Left eye Cornea, Right eye_ Left eye 20 Retinae, if not examined, so indicate, Right eye Snellen chart vision (uncorrected) Right eye Left eye Lest eye (corrected) Right eye person (Nes | No 3. Orientation: date X Yes D No place IX Yes | No Memory: recent and remote events Nes D No Other psychiatric abnormalities: A None I Any - Describe
4. Head: any deformities or areas of tenderness: E None I Any - Describe 5. Periorbirtal margins: any recent scars, tenderness or swelling XI None | Any - Describe WCW 018424

CONFIDENTIAL

| 6: Ears: Auditory canals, Right Left : Ear drums, if drums are not visualized, pecause of cerumen, so state |
|--|
| Right Left Discharge New Mastoid tenderness NOW |
| . 'Auditory aculty for conversational voice; indicate if normal or grossly impaired; Right ear Left ear |
| 7. Nose: 1 Normal Abnormal - Describe |
| 8. Oropharms: O Normal O Abnormal - Describe |
| Tongue: Normal C Abnormal - Describe |
| Gums Normal Abnormal - Describe |
| Teeth Normal O Abnormal - Describe |
| 9. Neck: Normal Abnormal - Describe |
| 10. Thorax: Lungs: Fremitus Normal Describe |
| Percussion note Normal O Abnormal - Describe |
| Asculatory findings: Normal Abnormal - Describe inside at or outside |
| Treat and Caracteristics of interspect |
| Midclavicular line ; Quality of heart sounds A Good U Fair U Poor Rhythm: A Regular U Irregular - Describe |
| Arrhythmia or thrills, present: No O Yes - Describe: |
| Murmurs present (No () Yes - Describe: Systolic or diastolic, Location of max intensity |
| Direction of transmission: Describe quality |
| Resting ventricular rate 95 Resting radial pulse rate 95 Resting blood pressure 112797 |
| Pulse rate immediately after exercising: 20-bendings 2 min. after exercise Blood pressure 3 min. after exercise |
| 11. Abdomen: X Normal O Abnormal - Describe |
| Scars, herniations, tender areas, or masses: ANo O Yes - Describe |
| Liver, spleen and kidneys (note any enlargement or tenderness): Normal D Abnormal - Describe |
| Inguinal region (note any tenderness, masses, scars or hernias): ANormal Abnormal - Describe |
| Genitalia: Penis: Normal D Abnormal - Describe |
| Testes: E. Normal Abnormal - Describe |
| |
| 13. Skin: DNormal DAbnormal - Describe |
| Lymphatic system (Examine cervical, maxillary, supraclavicular, axillary, epitrochlear, and inguinal node groups for adenopathy): |
| Normai []Abnormai - Describe |
| Lymphangitis present: No Yes - Describe |
| Status Thymico-Lymphaticus (note any sparse distribution of hair, soft skin, contour of thighs, generalized glandular enlargement, etc): |
| Present Absent - Describe |
| 14. Neurological: Gait Normal Abnormal Rhomberg Normal Abnormal Finger to nose test Normal Abnormal |
| Knec jerks Normal Abnormal; Biceps jerks Normal Abnormal; Babinski Normal DAbnormal; Brudzinski Normal abnormal |
| Describe any abnormalities |
| 15. Musculoskeletal System: Posture D. Normal Describe |
| Spinal curvature Normal OAbnormal - Describe |
| Any spinal tenderness, deformity, or limitation of motion: A No D Yes - Describe Extremities (note any deformity, pilonidal cyst, prostatic pathology, etc): A Normal Describe |
| Sear arthors. Rt Kree and ligament Strength. |
| 16. Obligatory laboratory data: |
| Heinelunia S.C. 1.0/S reaction sugar ~ albumin 7 C |
| HTV-N Negative Positive (Please attach original test results) EKG (Please attach original test results) |
| 17 Additional laborations date shall be collected if determined to be recessary by the physician (Please attach lest results): |
| Microscopic Examination, X-ray of the chest, chemistry panel, any recent laboratory data available. |
| 18. If wrestler is 36 years or older additional obligatory data required: |
| Verology, C.B.: A DVT/VLV Treberro P |
| Summarize all positive findings, if any, and indicate your clinical interpretation of this data: |
| |
| Recommendations for further specialized examination and/or consultation: |
| Accommendations for the spectrum of the spectr |
| |
| STATEMENT OF PHYSICIAN |
| |
| |
| at my office elsewhereck on this day of day of day of |
| have approved him for Wrestling have not approved him for Wrestling and do not recommend further studies because of obvious clinical disease |
| O Other parents |
| Other remarks CONCENTRA MEDICAL CENTER 3580 ATLANTA AVENUE |
| T.L. L. OSCA- 6 NO HAPEVILLE, GA. 30354 |
| Physician Name Office Address |
| 111)31(11111111111111111111111111111111 |
| 404-768-3351 /K/mmm 3 Hug 99 |
| Office Phone Physician Signature |
| WCW 018425 |
| CONFIDENTIAL |
| |

| Interpretable of the property | HHM VIUME | | =' | ~~~ | OSHA FILE No. | |
|--|---|--|-------------------|--|----------------------|--|
| Deport Fronce No. MORLD CHAMPIONSHIP WRESTLING 2865 LOG CABIN DRIVE SMYRNA, SSE 30080SPORTS ENTERTAINMENT City Simulation of Deports (Price) Propose Lambor Address of Location) Propose Lambor Address of Location) Occupation O | GEORGIA STATE BOARD OF WORKERS THE OVER'S FIRST REPORT OF INJURY OF | R OCCUPATION | L DISEASE | Ţ | | |
| MORILO CHAMPIONISHIP WRESTLING 2665 LOG CASIN DRIVE SIMTANA GAT 300 BOS PURT'S ENTERTAINMENT City Similar City | Proplement Phone No. | | | | TPA/Claims | Office |
| 2655 LOG CABIN DRVE SMYRNA CSA*2000SPORTS ENTERTAINMENT City Sum2Zap County of Injury City Sum2Zap County of Injury County of Injury County of Injury City Sum2Zap County of Injury County | nyar (| Timbrier F | <u>พ </u> | | TPA FEIN | |
| SMYFINA SEA 30080SPORTS ENTERTAINMENT City Status Status Status (Address of Location) City Status | MORLD CHAMPIONOFIII TYTEOTEINE | 531 | -811-4 | 14 | 1.11-111 | |
| Cry State 2 Country of Information Address of Locations) Cry State 2 Country of Information Country of Informatio | SMYRNA TSA 30080SPORT | SENTE | RTAIN | MENT | AGEN | |
| Stand Fig. 1 Property Propert | | | | State Zip | | V 1 |
| Due of Pirith Country of Injury Description Country of Injury Description Desc | · · | Occupation | acala in | <u> </u> | TPA/Claim | Office Phone No. |
| Description of the property of | | - M | | | County of I | njury |
| County of Highland County | Noyee Name (Lest) (First) (Aliddle) | (a) | 1-4-10 | <u> </u> | Employee S | Social Security Number |
| THIS COULD THIS COULD THIS COULD THIS COULD THIS COULD This Workshap Begin Date Employee Work for Near Day? Did Did Employee Work for Day of Day of For Day of | 8 Clas Sander Daire 716-68 | 1400 - | ~~~~ | U:O | OCAU- | ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~ |
| Country of Injury of Inj | State/Zip Employer's Horne | 7s.# | Number of De | perdents Includia | ng Spouse | THIS COLUMN |
| Did Employee Work for Next Day? Did | | Percen | Date Employe | Notified | | Insulet No. |
| Date of Strick Date of Days Number of Bays Number of Days Number of Days Number of Bays | (/\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ | First Date Erro | | The Erminate R | sceive Full | SIC |
| Date of first payment: O Year Warshor of Days La Yournally Schapfuled Wage Reig of Time of July of Date of Injury of Disease Washing Plant Wage Reig of Other selventages were furnished, country of Injury of Disease Washing Programs Wage Reig of other selventages were furnished, country of Injury of Disease Part of Body Affected Washing Programs Was | PP TO LONG | D Works Full | | Yes | ujuny/ □ No | Date of Birth |
| Total/Preserved Physician (Name and Address) Returned to Work, Cliver Date of Depth Physician (Name and Address) Preserved by Grin of Dyes Returned to Work, Cliver Date of Depth Physician (Name and Address) Preserved by Grin of Dyes Returned to Work, Cliver Date of Depth Physician (Name and Address) Preserved by Grin of Dyes Returned by Grin of Dyes Returned by Grin of Dyes EMPLOYER'S FABURE TO SUBMIT THIS REPORT TO INSUREE IMMEDIATELY MAY RESULT IN FENALTY FOR USE BY INSURERSE IMMEDIATELY MAY RESULT IN FENALTY Returned by Grin of Dyes Penalty paid: \$ Previously Medical Only Yes Q No Q Intelligence of Season P | urs Worked Number of Days List Norms | ally Scheduled | Wage Raig | | (4) (4-) | Sex |
| All Injury/Illness Exposure Octor on Employer's Premised washing to comparison on the Employer's Premised washing to comparison on the Employer's Premised washing of Injury/Illness Part of Body Affected Nature Yes a No by Nature Andrews Yes a No by Nature Yes and Nature Yes | | | lodering or other | dvantages were | hand, | County of injury |
| All Injury/Illness Exposure Ocole on Employer's Premiser Yes I No | XIPLETE WAGE STATEMENT ON REVERSE: If employed in particularly on confining of the company of the property amount | | rage weekly =110 | | | Employer Aware |
| Yes No No No No No No No N | TONOTICIONAL INVECTO LIBER | Type of | injury/libress | Part of Body | Affected | Nature |
| Resumed to Work, Give Date Resumed at What Wage Details Teaching Physician (Name and Address) Details Physician (Name and Address) Details D | van Nod | - tm | Beca_ | I-JKI I | <u> </u> | |
| TREATMENT OWNER, CITY DETERMINED AT MARKET POPT WORK Treatment to Work, City Determined at What Wage per Week Treatment to Work, City Determined and Address) Treatment to Work, City Determined and Address) Treatment to Work the per Week Treatment to Minor. By Employer O Minor. By | ow Injury or Illness Abnormal Health Condition Occurred. | csHind | | | | Body Part |
| Treating Physician (Name and Address) M.O. C. C. C. C. C. C. C. | Returned to Work, Give-Date Returned at What Wage | a | | | | Cause |
| Description of Date of Respective Person Filing Form and Sign) Of Format Controvert Of Minor: Clinia/Respital Of Emergency Core Of Minor: Clinia/Respital Of Emergency Core Of Hospitalized > 24 tes. Description Core Of Hospitalized > 24 tes. Description Core Of Hospitalized > 24 tes. Of Telephone Number Core Of Hospitalized > 24 tes. Of Telephone Number Core Of Respital Core Emergency Core Of Hospitalized States Insured Core Of Telephone Number Core Of Telephone Number Core Of Telephone Number Core Of Respital Core Of Respital Core Of Respital Core Of Respital Core Of Telephone Number Core Of Respital Core Of | | ,, | 1 | Copital (Name & | (Address) | M.O. |
| O Emergency Care O Hospitalized > 24 tax MCO Yes O No O Telephone Number OB 318 Date of Ref EMPLOYER'S FAILURE TO SUBMIT THIS REPORT TO INSURER IMMEDIATELY MAY RESULT IN PENALTY EMPLOYER'S FAILURE TO SUBMIT THIS REPORT TO INSURER IMMEDIATELY MAY RESULT IN PENALTY EMPLOYER'S FAILURE TO SUBMIT THIS REPORT TO INSURER IMMEDIATELY MAY RESULT IN PENALTY FOR USE BY INSURER.SELF-INSURER Average weekly wage: \$ Wockly benefit: \$ Previously Medical Only Yes CI No O BENEFITS ARE FAYABLE FROM Total/temporary sonal disability O Temporary partial disability O Permanent partial disability of % to for Fart of Body UNITIL WHEN THE EMPLOYEE ACTUALLY RETURNED TO WORK ALL OTHER SUSPENSIONS REQUIRE TO THE INSURER SUSPENSIONS SU | on Ciample | D Minor. By En | abjoher | | | Controvert |
| Compensation paid: \$ Penalty paid: \$ Previously Medical Only Yes CI No CI Telephone Number OF All Date of Ref. Note: \$ Previously Medical Only Yes CI No CI Telephone Number OF All Penalty EMPLOYER'S FAILURE TO SUBMIT THIS REPORT TO INSURER IMMEDIATELY MAY RESULT IN PENALTY EMPLOYER'S FAILURE TO SUBMIT THIS REPORT TO INSURER IMMEDIATELY MAY RESULT IN PENALTY FOR USE BY INSURER.SELF-INSURER. Average weekly wage: \$ Weekly basefit: \$ Date of first payment: Compensation paid: \$ Previously Medical Only Yes CI No CI EMPLOYER'S FAYABLE FROM FOR: FOR: O Toul/Aemporary total disability O Temporary partial disability O Permanent partial disability of M to Fart of Body UNTIL WHEN THE EMPLOYEE ACTUALLY RETURNED TO WORK ALL OTHER SUSPENSIONS REQUIRE TO THE SUSPENSION OF THE EMPLOYEE. By (Insurer/Self Insurer: Type or Print Name of Person Filing Form and Sign) (Date) (Phone) (Extensible Will not be paid because: By (Insurer/Self Insurer: Type or Print Name of Person Filing Form and Sign) (Date) (Phone) (Extensible Will not be paid because: By (Insurer/Self Insurer: Type or Print Name of Person Filing Form and Sign) (Date) (Phone) (Extensible Will not be paid because: | 220 70WOW 7017 101 101 101 101 101 101 101 101 10 | O Emergency Ca | ore l | | | N Sie |
| RESOLD Print of Type) Position COV Telephone Number 318 Date of Reg EMPLOYER'S FAILURE TO SUBMIT THIS REPORT TO INSURER IMMEDIATELY MAY RESULT IN FENALTY EMPLOYER'S FAILURE TO SUBMIT THIS REPORT TO INSURER IMMEDIATELY MAY RESULT IN FENALTY EMPLOYER'S FAILURE TO SUBMIT THIS REPORT TO INSURER IMMEDIATELY MAY RESULT IN FENALTY FOR USE BY INSURER SELF-INSURER Average weekly wage: \$ Weekly benefit: \$ Pate of disability: Date of first payment: FOR: Date of first payment: FOR: For O Tomb/temporary total disability: Temporary partial disability: Temporary partial disability: Temporary partial disability: Temporary partial disability of Main for Partial disability: WHEN THE EMPLOYEE ACTUALLY RETURNED TO WORK. ALL OTHER SUSPENSIONS REQUIRE TO THE INSURER SURFACE SUBMIT TO THE INSURER SURFACE SUBMIT TO THE INSURER SURFACE S | (4ML) 3FF- 106FF 7300 | □ Hospitalized> | 24 lus. | | | 1 |
| EMPLOYER'S FAILURE TO SUBMIT THIS REPORT TO INSURER IMMEDIATELY MAY RESULT IN PENALTY EMPLOYER'S FAILURE TO SUBMIT THIS REPORT TO INSURER IMMEDIATELY MAY RESULT IN PENALTY FOR USE BY INSURER/SELF-INSURER Average weekly wage: \$ Wockly benefit \$ Date of disability: Date of fast payment: Compensation paid: \$ Penalty paid: \$ Previously Medical Only Yes Q No D FOR: BENEFITS ARE PAYABLE FROM FOR: O Total/temporary total disability O Temporary partial disability O Permanent partial disability of May Pert of Body UNTIL WHEN THE EMPLOYEE ACTUALLY RETURNED TO WORK. ALL OTHER SUSPENSIONS REQUIRE THE FILING OF FORM WC2 WITH THE STATE BOARD OF WORKERS' COMPENSATION AND THE EMPLOYEE. By (Insurer/Self Insurer: Type or Print Name of Penson Filing Porm and Sign) (Oate) (Phone) (Extense of Benefits will not be paid because: By (Insurer/Self Insurer: Type or Print Name of Person Filing Form and Sign) (Date) (Phone) (Extense of Benefits will not be paid because: By (Insurer/Self Insurer: Type or Print Name of Person Filing Form and Sign) (Date) (Phone) (Extense of Benefits will not be paid because: | (10000000000000000000000000000000000000 | | No - Telep | oos Number | 1.211 | Date of Report |
| EMPLOYER'S FAILORE. TO SUBSTITUTE SUBSTITUTE STATE BOARD OF FORM WCI WITH THE STATE BOARD OF WORKER'S COMPENSATION AND THE EMPLOYER. BY (Insurer/Self Insurer: Type or Frimi Name of Person Filling Form and Sign) (Insurer/Self Insurer: Type or Frimi Name of Person Filling Form and Sign) (Insurer/Self Insurer: Type or Frimi Name of Person Filling Form and Sign) (Insurer/Self Insurer: Type or Frimi Name of Person Filling Form and Sign) (Insurer/Self Insurer: Type or Frimi Name of Person Filling Form and Sign) (Insurer/Self Insurer: Type or Frimi Name of Person Filling Form and Sign) (Insurer/Self Insurer: Type or Frimi Name of Person Filling Form and Sign) (Insurer/Self Insurer: Type or Frimi Name of Person Filling Form and Sign) (Insurer/Self Insurer: Type or Frimi Name of Person Filling Form and Sign) (Insurer/Self Insurer: Type or Frimi Name of Person Filling Form and Sign) (Insurer/Self Insurer: Type or Frimi Name of Person Filling Form and Sign) (Insurer/Self Insurer: Type or Frimi Name of Person Filling Form and Sign) (Insurer/Self Insurer: Type or Frimi Name of Person Filling Form and Sign) (Insurer/Self Insurer: Type or Frimi Name of Person Filling Form and Sign) (Insurer/Self Insurer: Type or Frimi Name of Person Filling Form and Sign) (Insurer/Self Insurer: Type or Frimi Name of Person Filling Form and Sign) (Insurer/Self Insurer: Type or Frimi Name of Person Filling Form and Sign) (Insurer/Self Insurer: Type or Frimi Name of Person Filling Form and Sign) (Insurer/Self Insurer: Type or Frimi Name of Person Filling Form and Sign) (Insurer/Self Insurer: Type or Frimi Name of Person Filling Form and Sign) | Transfer Windson | 100 400 | r. 1 | 14.00 | SULT IN PE | O Large |
| Average weekly wage: \$ | EMPLOYER'S FAILURE TO SUBMIT THIS FO | R USE BY INSURI | RISELF-INSU | UER | | |
| BENEFITS ARE PAYABLE FROM FOR: Distal/temporary total disability Of Temporary partial disability Of Permanent partial disability of Management partial disability of Management partial disability of Part of Body WHEN THE EMPLOYEE ACTUALLY RETURNED TO WORK. ALL OTHER SUSPENSIONS REQUIRE TO WORK OF FORM WC2 WITH THE STATE BOARD OF WORKERS' COMPENSATION AND THE EMPLOYEE. By (Insurer/Self Insurer: Type or Print Name of Person Filing Porm and Sign) (Date) (Phone) (Extense Person Will not be paid because: By (Insurer/Self Insurer: Type or Print Name of Person Filing Form and Sign) (Date) (Phone) (Extense Person Filing Form and Sign) | VARIABLE MCCOTA MARIE | | | | | Апен- |
| O Total/temporary social disability O Temporary partial disability O Permanent partial disability Part of Body WHEN THE EMPLOYEE ACTUALLY RETURNED TO WORK. ALL OTHER SUSPENSIONS REQUIRE TO CONTILL WHEN THE EMPLOYEE. FILING OF FORM WC2 WITH THE STATE BOARD OF WORKERS' COMPENSATION AND THE EMPLOYEE. By (Insurer/Solf Insurer: Type or Print Name of Person Filing Form and Sign) (Date) (Phone) (Extens NOTICE TO CONTROVERT PAYMENT OF COMPENSATION (over for additional information) Benefits will not be paid because: By (Insurer/Solf Insurer: Type or Print Name of Person Filing Form and Sign) (Date) (Phone) (Extens the Control of Person Filing Form and Sign) (Date) (Phone) (Extens the Control of Person Filing Form and Sign) (Date) (Phone) (Extens the Control of Person Filing Form and Sign) (Date) (Phone) (Extens the Control of Person Filing Form and Sign) (Date) (Phone) (Extens the Control of Person Filing Form and Sign) (Date) (Phone) (Extens the Control of Person Filing Form and Sign) (Date) (Phone) (Extens the Control of Person Filing Form and Sign) (Date) (Phone) (Extens the Control of Person Filing Form and Sign) (Date) (Phone) (Extens the Control of Person Filing Form and Sign) (Date) (Phone) (Extens the Control of Person Filing Form and Sign) (Date) (Phone) (Extens the Control of Person Filing Form and Sign) (Date) (Phone) (Extens the Control of Person Filing Form and Sign) (Date) (Phone) (Extens the Control of Person Filing Form and Sign) (Date) (Phone) (Extens the Control of Person Filing Form and Sign) (Date) (Phone) (Extens the Control of Person Filing Form and Sign) (Date) (Phone) (Extens the Control of Person Filing Form and Sign) (Date) (Phone) (P | Comparation years a | | | ************************************** | | 1 |
| UNTIL WHEN THE EMPLOYEE ACTUALLY RETURNED TO WORK. ALL OTHER SUSPENSIONS REQUIRE TO FILING OF FORM WC2 WITH THE STATE BOARD OF WORKERS' COMPENSATION AND THE EMPLOYEE. By (Insurer/Schi Insurer: Type or Print Name of Person Filing Form and Sign) (Date) (Phone) (Phone) (Extense of Person Filing Form and Sign) (Date) (Phone) (Extense of Person Filing Form and Sign) (Date) (Phone) (Extense of Person Filing Form and Sign) (Date) (Phone) (Extense of Person Filing Form and Sign) | | O Permanent part | isi disability of | % to | Part of Box | Fy for * |
| By (Insurer/Self Insurer: Type or Print Name of Person Filing Form and Sign) (Date) (Phone) (Phone) (Extense of Person Filing Form and Sign) (Date) (Phone) (Phone) (Extense of Person Filing Form and Sign) (Date) (Phone) (Extense of Person Filing Form and Sign) (Insurer/Self Insurer: Type or Print Name of Person Filing Form and Sign) (Insurer/Self Insurer: Type or Print Name of Person Filing Form and Sign) (Insurer/Self Insurer: Type or Print Name of Person Filing Form and Sign) | | PE ACTUALLY RE | TURNED TO W | ORK ALLOTI | ier suspens | SIONS REQUIRE THE |
| By (Insurer/Self Insurer: Type or Print Name of Person Filing Form and Sign) (Date) (Phone) (Extense C. NOTICE TO CONTROVERT PAYMENT OF COMPENSATION (ever for additional information) | UNTIL FILING OF FORM WC2 WITH THE STATE BOARD OF WORKE | RS' COMPENSATI | ion and the i | MPLOYEE. | | |
| C. NOTICE TO CONTROVERT PAYMENT OF CONTROVERT PAYMENT PA | Ву | No. Com and Size | (0) | ate) | | |
| By (Insurer/Solf Insurer: Type or Print Name of Person Filling Form and Sign) (Date) (Phone) (Extens (Insurer/Solf Insurer: Type or Print Name of Person Filling Form and Sign) (Date) (Phone) (Phone) (Extension (D.C.G.A. \$349-18 and \$349-19). | C. NOTICE TO CONTROVERT | PAYMENT OF CO | MIPENSATIO | (ever for addit | INCH INTERIOR | |
| (Insurer/Self Insurer: Type or Frint Name of Person Filling Form and Sign) (Deta) | Heneins will not be been excessed: | in the second se | •• | | | |
| willfully realized a false statement for the purpose of obtaining of desyring benefits is a critical subject to personal of the instrument for the purpose of obtaining of desyring benefits is a critical subject to personal of the purpose of obtaining of desyring benefits is a critical subject to personal of the purpose of obtaining of desyring benefits is a critical subject to personal of the purpose of obtaining of desyring benefits is a critical subject to personal of the purpose of obtaining of desyring benefits is a critical subject to personal of the purpose of obtaining of desyring benefits is a critical subject to personal of the purpose of obtaining of desyring benefits in the purpose of obtaining of the purpose of obtaining obtaining of the purpose of obtaining o | (insurer/Solf insurer: Type or Print Name of Person I | Filing Form and Sign |) (I | (ste) | (Photos (O.C.S.A. E) | ne) (Extension 4-9-18 and \$34-9-19). |
| JUST Martid it noted DIO not want to see of EMPLOYERS THE DIO OR OCCUPATIONAL | withilly training a foles summer for the purpose of obtaining or denying benefit | THE CHIM ENGINEE AT | 力5cc0 | EMPLO | | |

CONFIDENTIAL

WCW 002617

INITIAL VISIT EVALUATION West Paces

5/24/2 **Bobby Walker** PATIENT: May 4, 2000 DATE:

IIISTORY: Bobby was referred by WCW for evaluation and treatment of his left knee. Approximately a month ago, while in the ring, he caught a wrestler, twisted his knee and felt a pop. He had a large amount of swelling immediately. He rehabled his knee with the swelling going down." He has however had additional episodes of giving way and swelling of his knee. doing simple activities such as mowing his lawn.

EXAM: Examination of the knee reveals a 1+ effusion, range of motion is 5 to 110, he has 2 to 3+ Lachman's, 1+ pivot shill, 1+ anterior drawer, and positive medial joint line tenderness.

DIAGNOSIS: Probable anterior cruciate ligament tear with medial meniseus tear.

PLAN: The plan is to obtain an MRI of his knee to evaluate for pathology. He was given Culubras samples to take to help with his current effusion. He will continue to rehab his knee since he is familiar with the appropriate exercises. Recheck will be after MRI is performed.

m Michael D. Ciepiela, MD

MDC:Is

CONFIDENTIAL

WCW 002619

Henderson, Debbie

From:

Myers, Diana

Sent:

Wednesday, June 07, 2000 9:18 AM

To: Subject: Henderson, Debbie RE: Bobby Walker

)

keep a copy of this e-mail in the file.

dm

-Original Message

Henderson, Debbie

Sent:

Tuesday, June 06, 2000 4:43 PM

To: Subject: Myers, Diana

Importance: High

Bobby Walker

Yesterday I received a message from Sharon at One Call Medical (the CO. that schedules our MRI's, CT Scans, etc.) stating that Bobby was scheduled on 5/15 for an MRI and no showed that appt. Then he was rescheduled for 5/24 in which he called the location directly and cancelled. She says since 5/24 she has been trying to get in touch with him to reschedule again and he is not returning any of her calls or there is no answer at his home number. She asked me to see what I could do.

In trying his home today, I let him know that they have been trying to get in touch with him regarding getting the MRI done, and he stated the knee feels better, and that he wanted to wait on the MRI. He said he would call if he felt he needed to have it done after a couple of weeks.

Just wanted you to know.

Thank You!!

Debbie Henderson/WCW Risk Mgmt. Ph-(404) 603-3118 Fax-(404) 603-4017 Cell-(404) 281-0622